HASCAS
Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment Provided to Mr X and Mr Y

by the

East London NHS Foundation Trust

EXECUTIVE SUMMARY

Commissioned by NHS England

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Contents

1. **Investigation Team Preface** Page 2
2. **Condolences to the Family and Friends of Mr Y** Page 2
3. **Incident Description and Consequences** Page 3
4. **Terms of Reference** Page 4
5. **The Independent Investigation Team** Page 5
6. **Identification of the Thematic Issues** Page 6
7. **Conclusions** Page9
8. **Notable Practice** Page 11
9. **Lessons for Learning** Page 12
10. **Recommendations** Page 13

1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of two mental health service users - Mr X (the perpetrator of the homicide) and Mr Y (the victim of the homicide) -was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Mr Y who was found dead on 21 June 2013.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr Y

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Mr Y. At the time of writing this report HASCAS had not yet been able to arrange a meeting with Mr Y's mother and children.

1. Health Service Guidance (94) 27

3. Incident Description and Consequences

Background for Mr X

3.1. Mr X is a 44 year old gentleman of Orthodox Christian Eritrean origin. He came to live in England in 1991 having fled Eritrea to avoid being enlisted into the army against his will. He has had no family contact since this time and has never reported a significant relationship with anyone. Mr X has been unemployed since 2005 because his mental health problems became too severe for him to work.

3.2. Mr X received two prison sentences in 2004 and 2009 for possessing a bladed object. The Prosecution Service (following the homicide of Mr Y) noted that Mr X also had three other convictions between 2001 and 2013 for theft and three cautions (one of these also for theft and one for possessing a bladed article). Mr X had not been known to be involved in any act of violence prior to the homicide of Mr Y.

3.3. From as early as 2001 Mr X came to the attention of mental health services. In 2006 he registered with the Health E1 Homeless Medical Centre - a primary health care facility for the homeless in Tower Hamlets. This led to him being referred to the Specialist Addictions Unit at Tower Hamlets in 2008. In December 2010 Mr X went to live at Daniel Gilbert House - a hostel for the homeless which is supported living accommodation. Over the years it became apparent that Mr X experienced psychotic symptoms and in February 2011 a referral was made to the Bethnal Green Community Mental Health Team – he was placed on a full Care Programme Approach (CPA).

3.4. Mr X continued to have input from all four services until the time of the homicide. He had a diagnosis of Paranoid Schizophrenia/Schizoaffective Disorder and Polysubstance Misuse. In May 2013 Mr X was taken off full CPA as he appeared to be stable at this time.

Background for Mr Y

3.5. Mr Y was a white British gentleman who was 44 years old when he died. At the time of his death he was living at the Daniel Gilbert Hostel where Mr X also lived. He was registered with the Health E1 Homeless Medical Centre where he received a service for his many physical problems. Mr Y had a longstanding polysubstance misuse problem and was a service user with the Specialist Addictions Unit at Tower Hamlets. He had six children in care and begged on the streets. Mr Y had 36 convictions for 70 offences – mostly in relation to drug dealing and theft. During his time living at the Daniel Gilbert Hostel he was involved in numerous fights and altercations which led to him being injured on several occasions.

Incident Description and Consequences

3.6. On 21 June 2013 it was noted by staff who worked at the hostel that Mr Y was in good spirits. He had won £900.00 on the roulette table at the *"bookies"*. Mr Y spent time at the hostel between 10.30 -11.00 and later on in the afternoon when he left with a fellow resident. Prior to the homicide Mr X and Mr Y had been in a dispute about a drug debt; Mr X wanted payment and Mr Y refused.

3.7. A report prepared for the Court stated that between 18.30 and 19.00 staff at the hostel heard loud shouting and screaming coming from Mr X's room. Members of staff went to investigate. Mr X opened his door and apologised for the noise. He was in an emotional state. There was no one else in the room. A chest of drawers had burn marks on it and there was a device used for smoking drugs on the chest. Mr X left his room at around 18.45. The hostel staff took the opportunity to examine the defendant's room more thoroughly. The smoking device had gone.[2]

3.8. Around 19.00 Mr X returned to his room. He was in an angry and upset mood. A few minutes later the shouting started again. The police were called but they advised hostel staff to contact the mental health team as no offense was being committed. Hostel staff called mental health services but received an out of office reply. Mr X calmed down after support from hostel staff was given and he apologised for his behaviour.

3.9. CCTV footage showed Mr Y returning to the hostel at 21.37 – he was alone. The same CCTV captured Mr X leaving the hostel at 21.55 – he was never to return.

3.10. The following day at around 17.00 a member of the hostel staff went to check on Mr X. There was no reply so she entered his room using a master key. Mr Y was found lying on his left side with a severe injury to his throat. My Y was examined by paramedics and life declared extinct at 17.34.

3.11. Mr X was not apprehended until 9 July 2013. He was arrested at the Elephant and Castle shopping centre. When asked what he knew about the murder of Mr Y Mr X replied *"I don't know … [Mr Y] but I heard something bad had happened".* He was arrested and made no reply to caution. Subsequently Mr X was convicted of the murder of Mr Y and sentenced on 6 March 2014 to life imprisonment. He is detained at HMP Belmarsh Prison.

4. Terms of Reference

4.1. *"Individual Terms of Reference will be developed in collaboration with the successful Offeror for each individual investigation. However, the following generic terms of reference will apply to each investigation:*

- *Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.*
- *Review the progress that the trust has made in implementing the action plan.*
- *Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence.*
- *Compile a comprehensive chronology of events leading up to the homicide.*
- *Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.*

[2]. Psychiatric Report for Central Criminal Court (3 March 2014)

- *Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.*
- *Examine whether either service user should have been managed under Safeguarding Vulnerable Adults procedures. Also examine the issue of increased service user vulnerability to homicide and violence and ascertain whether either Mr X or Mr Y should have been managed specifically with these factors in mind.*
- *Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.*
- *Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.*
- *Review and assess compliance with local policies, national guidance and relevant statutory obligations.*
- *Consider if this incident was either predictable or preventable.*
- *Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.*
- *Assist NHS England in undertaking a brief post investigation evaluation".*[3]

5. The Independent Investigation Team

Selection of the Investigation Team

5.1. The Investigation Team was comprised of individuals who worked independently of the East London NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Dr Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service - Chair, nurse member and report author

Investigation Team Members

Dr Elizabeth Gethins	Health and Social Care Advisory Service - Associate, Consultant Psychiatrist - medical member
Mrs Tina Coldham	Health and Social Care Advisory Service - Associate, service user member
Mr Frank Mullane	Health and Social Care Advisory Service - Associate, lay member
Ms Sara Egan	Health and Social Care Advisory Service - Associate, housing and

[3]. NHS England London Region 23 March 2015

	addictions member

Support to the Investigation Team

Mr Greg Britton	Health and Social Care Advisory Service Investigation Manager

Independent Advice to the Investigation Team

Ms Janet Sayers	Solicitor: Kennedys

6. Identification of the Thematic Issues

Thematic Issues

6.1. The Independent Investigation Team identified 14 thematic issues that arose directly from analysing the care and treatment that Mr X received from the East London NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis and Presentation.** In the case of Mr X it took several years for health care workers to diagnose what mental illness he actually had and he was rather belatedly seen through the lens of Paranoid Schizophrenia (and more latterly Schizoaffective Disorder) instead of just his polysubstance misuse. This served to delay him receiving a care and treatment package that could address his needs for several years.

   In the case of Mr Y - who had a diagnosis of polysubstance misuse and depression - no specific issues emerged; it was noted that both his mental and physical health problems were identified and treated in a timely manner.

2. **Medication and Treatment.** Mr X had a history of occasional non-compliance with his medication and a variation in his levels of insight for its continued use. During the last three months prior to the killing of Mr Y, and following his discharge from CPA, it would appear that he had not been taking his medication (based on reports to the Court). It is evident that there were no plans in place to monitor this situation. Also in the case of Mr X it was also noted that his Methadone prescription was below a therapeutic dose and perhaps the continued prescribing of this should have been reviewed with a view to stopping it. From a general treatment point of view there were plans for psychoeducation and CBT – which was good practice – but Mr X did not want to comply.

   In the case of Mr Y a significant finding was made in relation to his Diazepam prescription. On occasions this was prescribed even when he tested negative for Benzodiazepines and there is clear evidence that he was dealing Diazepam on a regular basis at the hostel in which he lived. The Independent Investigation Team was also told that a friend of Mr Y, to whom he dealt drugs, had died of a Diazepam overdose. Whilst no connection can be made to the Diazepam prescribed to Mr Y and his drug dealing habits it is a precautionary finding in relation to the management of people with a chaotic and drug-dealing lifestyle.

3. **Use of the Mental Health Act (1983 and 2007).** Neither Mr X nor Mr Y appeared to have met the criteria for a Mental Health Act assessment during the time they were engaged with service. Whilst both service users experienced crises these were managed appropriately on an informal basis.

   It is evident that Mr X acted out of character immediately prior to the homicide of Mr Y. However he was not assessed and it has not been possible to ascertain whether or not he would have met the criteria for a Mental Health Act (1983 & 2007) assessment on this occasion.

4. **Care Programme Approach (CPA).** Mr X was on full CPA between May 2011 and May 2013. It was evident that he was eligible for CPA a considerable time earlier but the referral process failed to access the help he needed for a year. During this year he became mentally unwell, lost his accommodation and became street homeless - all of which could possibly have been avoided had he followed a more appropriate care pathway. In May 2013 the decision was taken to discharge Mr X from full CPA – in itself this decision was reasonable – however it was undertaken without full communication first taking place between the hostel and the SAU. This meant that the continuing care and risk management plans of the hostel and SAU were implemented without a full understanding of the reduced input from the CMHT. At the point of his discharge from CPA Mr X had no ongoing plan that all services were signed up to.

   Mr Y was not eligible for CPA and no findings were made.

5. **Risk Assessment.** The Independent Investigation found that the Specialist Addiction Unit, the hostel and the CMHT all conducted risk assessments but that these assessments were not routinely shared between the teams leading to important information being missed. There was also a ready acceptance in general of the homeless carrying knives and living chaotic lifestyles which in future should perhaps be captured in diagnostic and risk formulations for those identified as having a severe and enduring mental illness. In the case of Mr X this was not done and his polysubstance misuse, Schizophrenia, command hallucinations, vulnerability and gambling habits were not all brought together and assessed ‘in the round’. This was a significant omission.

   Both Mr X and Mr Y lived in hostel accommodation. The hostel population at Daniel Gilbert House was volatile. Each individual presented with a degree of risk – some of a relatively mild nature – others with significant risk profiles. The levels of risk within the hostel could rise and fall with no systematic process to monitor collective risk and there were weak mechanisms by which the service could escalate concerns and seek additional support.

6. **Referral and Discharge Planning (examined under CPA in section 12.4 of the report).** In the case of Mr X referral and discharge processes could have been managed better on two occasions: the first between May 2010 and May 2011 when the attempt to refer Mr X for Care Coordination failed; and the second being his discharge from CPA in May 2013. On both occasions the process was compromised by a lack of assertive communication that ensured all health and social care partners were directed appropriately.

7. **Safeguarding and Vulnerability.** The Independent Investigation found that there were different concepts of what constituted vulnerability in operation across each service. Neither Mr X nor Mr Y would have met the criteria for being a Vulnerable Adult in any legal sense of the definition. However on occasions both were rendered vulnerable by virtue of their lifestyle and mental and physical conditions. These issues were identified and clear strategies to manage them (particularly in respect of Mr X and Mr Y's continued self neglect) were put into place. However the issue of placing some 90 adults with varying states of vulnerability and anti-social behaviour into Daniel Gilbert House presents an ongoing situation that requires examination. The collective risk of placing so many people together serves to increase the need for an active multiagency safeguarding strategy.

8. **Housing.** Both Mr X and Mr Y had experienced periods of rough living on the streets. At the time of Mr Y's death they were both domiciled at Daniel Gilbert House – a hostel for the homeless. Both service users were eligible for Supported Living and as such accessed a significant amount of input from hostel staff. Overtime the amount of liaison between hostel staff and NHS teams varied. In the case of Mr X this effectively tailed off during the nine months prior to his discharge from CPA. This had the effect of distancing the hostel staff from the ongoing work conducted by the NHS and meant that there was a degree of ambiguity about how best to manage Mr X's mental health.

9. **Interagency/Service Working (examined under Housing in section 12.7 of the report).** There was a high degree of historical synergy between the Health E1 Homeless Medical Centre, the SAU, the hostel and the CMHT. It was evident that CPA reviews provided an opportunity for teams to come together to plan care and treatment and monitor progress. There was a consistent approach taken for both Mr X and Mr Y over the years. This was greatly facilitated by all services (apart from the hostel) being managed by the same provider – the East London NHS Foundation Trust.

   However during the nine months prior to Mr X's discharge from CPA and the death of Mr Y Care Coordination did not appear to work so well as previously and ongoing communication and liaison diminished, in particular with the hostel. This happened at a critical juncture in Mr X's care and treatment.

10. **Service User Involvement in Care Planning and Treatment.** Both Mr X and Mr Y were treated at all times by all services with respect, kindness and courtesy. Attempts were made on a constant basis to ensure full engagement was maintained no matter how chaotic either servicer user was in presentation. Complex mental and physical health conditions were managed by workers across all teams in a consistent manner that provided care and treatment against a backdrop of very challenging social conditions.

    However the Independent Investigation found no mention in the clinical record of any attempt ever having been made to understand Mr X in the light of his asylum seeker/refugee status. Levels of professional curiosity were low and no consideration of stigma, masking of symptoms, denial of symptoms etc. (common features in people from East Africa) is evident in the clinical record. Had this been achieved Mr X might have been understood better.

11. **Carer and Family Concerns.** Mr X had no family or friends who could act in a carer role. The hostel staff, as part of the Supported Living provision, acted in lieu of carers and as such should have been kept in close contact as they were Mr X's main protective factor much of the time. In the nine months prior to Mr X's discharge from CPA and the killing of Mr Y communication between hostel staff and the CMHT appeared to decline. This served to diminish the effectiveness of the ongoing care and treatment plan in place for Mr X.

    The SAU maintained contact with Mr Y's mother. This contact was put in place to ensure the continued safety of Mr Y and his family, who lived in Rochdale, on the occasions when he visited them. This was good practice.

12. **Documentation and Professional Communication.** In general the Trust clinical documentation for both Mr X and Mr Y was maintained well. It was noted that the record keeping maintained by the hostel was also of a good general standard. Over the years there were issues with letters sent out from the SAU and CMHT to other health colleagues with delays of up to eight weeks. This was noted on several occasions and would have served to slow down prescription advice and referral processes.

    Professional communication was maintained between health services. However as has already been identified above, Care Coordination did not provide a reliable communication channel in the months prior to Mr X's discharge from CPA. This was of particular note with regard to Daniel Gilbert House.

13. **Adherence to Local and National Policy, Procedure and Clinical Guidelines.** In general adherence to both Trust and hostel policy and procedure was good.

14. **Trust Clinical Governance and Performance**. The Trust was found to have robust clinical governance systems and procedures in place. Team workforce capacity was found to be within national best practice guidance allowing supervision to occur on a regular basis and for all staff to receive mandatory training and appraisal. The Trust operates a robust clinical audit process and no link was made between the homicide of Mr Y and governance failings on the part of the Trust.

7. Conclusions Regarding the Care and Treatment Mr X and Mr Y Received

Overview

7.1. Over the years both Mr X and Mr Y received compassionate care and treatment from both NHS and hostel services. The care and treatment was of a consistently good standard (generally in keeping with local and national best practice guidance) which ensured engagement was maintained so that it could be provided to two chaotic service users who were rendered vulnerable by virtue of both their lifestyle and diagnoses.

7.2. A particular feature was the excellent standard of care provided by the Health E1 Homeless Medical Centre, the Blood Bourne Virus Team, the Special Addictions Unit and the hostel. The approach taken was notable practice and ensured that both service users, but Mr Y in particular, were maintained at their optimum levels of physical health. This was no easy task and the Independent Investigation commends the teams for their work.

7.3. Investigations of this kind take a longitudinal view of care and treatment over many years. It is inevitable that there will be findings that are made that show on occasions services did not always work as well as policy guidance suggests they should. However this is part of the normal day-to-day provision of mental health service and it is to the credit of all teams involved that these omissions are relatively few – even if they were serious in nature.

7.4. The Independent Investigation Team found that communication between the CMHT, the SAU and the hostel was not of a consistent standard in the months leading up to Mr X's discharge from CPA. This was unfortunate in that it left those providing ongoing care and treatment to Mr X somewhat 'in the dark'. However we note that Mr X was retained on the CMHT caseload and there were plans to monitor him into the future even if those plans had perhaps not been so clearly articulated to Mr X or to the other services who continued to be involved with him. The Independent Investigation Team concludes that this was primarily a failure of communication on the part of Care Coordination and the CMHT.

7.5. However that being said the Independent Investigation Team made no causal connection between any act or omission on the part of either NHS or hostel teams and the killing of Mr Y. On balance it would appear that the fatal altercation between Mr X and Mr Y was probably related to an unresolved drug debt. There is no evidence to suggest the homicide was psychotically driven and could therefore have been managed by a mental health team even had one been called to the hostel on the evening of 21 June 2013.

Predictability and Preventability

Predictability

7.6. Whilst it was predictable that a violent untoward incident of some kind was likely to occur in the lives of both Mr X and Mr Y at some stage, the killing of Mr Y on the evening of 21 June 2013 could not have been predicted.

Preventability

7.7. Even if an incident cannot be predicted it can often be prevented providing sound processes are in place such as care planning, risk assessment and crisis and contingency arrangements. Mental health services are required to ensure that specific safety nets are put into place in order to ensure the continued health and wellbeing of the service user and also the general public. Whilst the Independent Investigation Team concludes that more could have been done to ensure Mr X's ongoing management plans were more clearly understood (by the hostel in particular) nothing could reasonably have been expected to have prevented the killing of Mr Y on 21 June 2013. The rationale for this is examined below using three tests of reasonability.

Knowledge:

7.8. Whilst hostel staff had concerns about Mr X's mental wellbeing on 21 June 2013 – the concerns appear to have been short lived and the situation whereby Mr X was shouting and irritable appeared to resolve itself. No one had any knowledge that Mr X planned to harm Mr Y or that he continued to be agitated once he had calmed down and apologised for his behaviour.

Opportunity:

7.9. Hostel staff sought to intervene by calling the police and telephoning the CMHT office number. However neither intervention accessed the support the hostel was seeking and to all intents and purposes the situation appeared to have resolved when Mr X calmed down and apologised for his angry outburst. No one at the hostel was aware that Mr X and Mr Y met later on in the evening and no one knew that Mr X had attacked and killed Mr Y until the following day when his body was found – hence there were no further opportunities to intervene.

Legal Means:

7.10. The Independent Investigation Team concludes that Mr X was experiencing some kind of crisis during the evening of 21 June 2013 – this was evident in that hostel staff found it severe enough to call the police. What can now not be known with certainty is whether this crisis was driven by Mr X's mental illness relapsing due to the fact out of hours mental health services were not contacted at the time to assess his mental state. However it was a finding of the Court that Mr X's capacity at the time of the killing was not diminished and this would suggest that he would not have met the criteria for detention under the Act on 21 June 2013 and that there were no legal means available to intervene.

8. Notable Practice

Service User-Centered Care and Treatment

8.1. All of the services involved over time in the provision of care and treatment to both Mr X and Mr Y delivered this with respect, kindness and courtesy. Attempts were made on a constant basis to ensure full engagement was maintained no matter how chaotic either servicer user was in presentation. Complex mental and physical health conditions were managed by workers across all teams in a consistent manner that provided care and treatment against a backdrop of very challenging social conditions. This consistent approach has been identified as notable practice.

Joined up Working

8.2. On the whole Mr X and Mr Y received reliable and joined up care and treatment from Trust-based services. This was in no small part due to the GP practice, the SAU and the CMHT all being provided by the same organisation within the same locality. This ensured a high degree of joint working was possible by teams with longevity of service who were used to putting the patient at the centre of the care pathway. This is an unusual model and it provides an exemplar way of delivering services to chaotic and homeless service users.

9. Lessons for Learning

Understanding the Service User – Cultural Competence

9.1. As has been noted above, Mr X was always treated with dignity and respect. However he was not fully understood in the context of his culture and ethnicity. Had this been managed better it is probable that the treating teams could have got 'underneath' Mr X's presentation and a more robust plan developed to manage and treat his Schizophrenia/Schizoaffective Disorder. The need for cultural competence on the part of care and treatment teams, and a full understanding of the service user in the context of culture and ethnicity, was jointly identified by the Independent Investigation team and the Trust at the lessons for learning workshop. Whilst a deeper understanding would not have prevented the death of Mr Y, it is reasonable to assume that it would have potentially improved the care and treatment approach taken and subsequently Mr X's quality of life.

Professional Communication

9.2. Professional communication is an essential factor in the management of safe patient care and treatment delivery. This has been a consistent finding from the 1990s onwards of independent homicide investigations, such as this one, working across the country. Whilst no causal factors were found in relation to the care and treatment Mr X received and the death of Mr Y, it is a fact that professional communication failed over the nine months prior to the killing of Mr Y. The role of the Care Coordinator is fundamental to the maintenance of good professional communication – all Care Coordinators should be made aware of this role and trained and supported to achieve maximum impact.

Safeguarding

9.3. It was a finding of both the Trust internal investigation and joint Serious Case Review and the Independent Investigation that guidelines for supported accommodation providers for managing vulnerable adults within their services needed to be developed further with all statutory services. The collective risk and safeguarding concerns for Daniel Gilbert House were understood poorly by health partners. Whilst the hostel was providing a service to Vulnerable Adults and those rendered vulnerable by virtue of their lifestyle little consideration was given as to how an individual's safeguarding risk could be elevated by being in a hostel environment rather than being managed and supported by it. The collective elevation of risk needs to be understood better and be more explicitly supported by guidelines and policy process.

10. Recommendations

Background

10.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

10.2. The Independent Investigation Team worked with the East London NHS Foundation Trust, Daniel Gilbert House and NHS Tower Hamlets Clinical Commissioning Group (at a lessons for learning workshop) to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process. **It should be noted that the Trust, the Local Authority, housing and the Tower Hamlets Clinical. Commissioning Group have all been working together to promote change and embed the learning from Mr Y's death. Therefore the recommendations below focus on embeddedness and the review and audit of the new ways of working.**

Progress Made To-Date

10.3. The Internal Investigation made the following recommendations:

1. *"The TH Directorate, with assistance from the LBTH Supporting People Team should extend its current protocol between CMHTs and mental health supported accommodation units to cover the homeless hostels in the Borough. The extended protocol should cover issues such as information exchange, CPA arrangements and expectations, and crisis contact arrangements.*

2. *LBTH should develop guidelines with their supported accommodation providers for supporting vulnerable adults within their services. The guidelines should be developed in consultation with the relevant ELFT teams, the CMHT, the SAU, Health E1 and the BBV team".*

10.4. **Recommendation 1:** Progress has been made with an active communication protocol having been developed. At the time of writing the report this protocol was in the process of being embedded.

10.5. **Recommendation 2:** It is less clear what exactly has changed in relation to this recommendation. When stakeholders and witnesses were met with it was evident that more needed to be done to ensure safeguarding guidelines were developed to specifically protect and manage individuals such as Mr X and Mr Y.

Recommendation One: Diagnosis

10.6. It was discussed at the lessons for learning workshop that a more *"stringent formulation"* process was required particularly for service users with a combined psychosis, substance misuse and forensic history. The issue was raised about the thresholds for forensic assessment to support diagnostic and risk formulation. The issue was also raised as to whether the Trust should lower the threshold for forensic assessment referral.

- **Action:** The Trust will review current liaison arrangements between locality directorates and Forensic Services, looking in particular at referral thresholds. The review will ensure that in future formulation processes will be sensitive enough to take into account complex presentations utilising the skills and services to be found within the organisation. This process will be completed within six months of the publication of this report.

Recommendation Two: Medication and Treatment

10.7. The role of housing should be clarified with regard to medication management. Some hostels in the area are required to support medication compliance and mental health monitoring – others are not. At the lessons for learning workshop we heard from the Tower Hamlets Clinical Commissioning Group that guidelines are now in place.

- **Action:** The Tower Hamlets Clinical Commissioning Group must review these guidelines in conjunction with health and housing partners to audit embeddedness and fitness for purpose. This process will be completed within six months of the publication of this report.

Recommendation Three: Referral System

10.8. The referral system has been improved since the transfer from paper to electronic records. Referrals are now highlighted and audited. The system is fully integrated at the present time

- **Action:** For the current arrangements to be audited within six months of the publication of this report.

Recommendation Four: Risk Assessment

10.9. Risk assessment processes need to be tightened for those service users with a stable/medium/long-term relationship with the Trust. Reviews should be conducted and an assurance provided that historic risk information is brought together and that ongoing/new risk information is considered as part of a dynamic risk assessment process as routine. Risk assessments should be multidisciplinary/agency and perhaps the CPA meeting should be used to assess risk in a more defined manner.

- **Action:** The Trust will develop an audit system sensitive enough to detect whether risk assessment is based upon historic information pertinent to the ongoing care and treatment of named service users. This to be developed within six months of the publication of this report.

Recommendation Five: CPA

10.10. A number of service users of the CMHTs have named Care Coordinators but are not subject to CPA. At present, no core CPA documentation such as Risk Assessment, Care Plan and Crisis and Contingency Plan need be maintained. It is noted that in the case of the incident in question, hostel staff had little information on the key professionals involved in Mr. X's care or how to respond in the event of a crisis.

10.11. Communications between the CMHT and hostel have significantly improved due to good practice initiatives. The Trust and the Local Authority etc. need to work through how the learning from the Mr X case, and the subsequent good practice arising from lessons for learning, can be rolled out across the whole Trust and other housing providers. We heard at the workshop that there was:

1. A new joint working protocol with simple guidelines to support housing providers accessing immediate support from secondary care mental health services (with a flow chart of all OoHs contacts).
2. Training to the Daniel Gilbert Hostel.
3. Work ongoing to consider a named CMHT link worker for each hostel/housing provider.
4. Work ongoing to consider how care, crisis and contingency plans can be made available to housing for all mental health service users even those who do not meet Care Coordination/CPA criteria.

17.12. A key point was identified as being the role of the Care Coordinator in pulling all of the agencies and services together in the best interests of the service user, and once designated this role had key responsibilities over and above those other practitioners in other services to ensure the ongoing flow of communication. Care Coordinators need to be more mindful of their role. The communication between CMHTs and GPs is now part of the CQUIN process.

- **Action 1:** for the work already in train to be reviewed within six moths of the publication of this report.

- **Action 2:** As a minimum care standard, service users who have a Care Coordinator but who are not subject to CPA will have a Crisis and Contingency Plan made available. This work should be embedded within six months of the publication of this report.

Recommendation Six: Interagency/Service Communication

10.13. The lessons for learning workshop discussed at length the issues around information sharing between agencies, particularly between health and hostels. The group decided that a core set of information should be agreed between the agencies and that this should form a recommendation. The recommendation should address issues pertaining to patient confidentially, consent, safety thresholds etc. It was also agreed that an information sharing protocol should also be developed in order to promote safety and joined up working. A profile should be developed that outlines what information is expected from each professional (across all services and agencies) involved with a service user. This profile should identify who needs to know what and when. A core dataset should be developed (e.g. risk and crisis plans, relapse information, change of workers, medication etc.). The core data set should apply to ALL service users whether they are subject to CPA/CMHT services or not.

10.14. The workshop acknowledged that there were often chaotic service users who did not meet CMHT thresholds and that satellite clinics should be provided for advice to hostels and primary care. It was recognised that different types of service users would require specific information sharing criteria to be identified.

- **Action 1:** Following the incident involving Mr X and Mr Y and prior to both the internal and independent investigations, the Operational Lead of Bethnal Green CMHT met with senior representatives of Providence Row Housing Association to debrief and to exchange ideas about how tools could be introduced in order to improve communication between agencies. A Joint Working Protocol was developed between Bethnal Green CMHT and Daniel Gilbert House which includes guidance on mutual communication. This was subsequently extended to all hostel providers within Tower Hamlets following discussion with these providers. This process will be reviewed within six months of the publication of this report.

- **Action 2:** A tool has been developed for hostels to advise how to access support if staff are concerned about a resident, whether known or unknown to secondary mental health services and whether within or outside the CMHT hours of operation. This was designed as a flow chart in poster form for easy reference. Training has now been delivered by the CMHT to hostel staff on both these tools. The Joint Working Protocol has been subject to a review cycle following which it was amended. These tools to be rolled out to other directorates. It may be necessary to amend content to reflect local variations. This process will be reviewed within six months of the publication of this report.

- **Action 3:** Relationships between the CMHTs and hostel providers can be developed, and continuity of care improved, by identifying a small number of Care Coordinators as Link Workers for each hostel. Link Workers to act as point of contact for the hostels and to act as Care Coordinators for all service users in their link hostel who require Care Coordination under the care of a specific team. A similar arrangement has been successful following implementation in mental health supported accommodation provision.

Changes of staffing to be clearly communicated between agencies. It was also agreed to consider, if practicable, the facilitation of CPA clinics at hostels and to develop an information sharing protocol between the CMHTs and hostels. This process will be reviewed within six months of the publication of this report.

Recommendation Seven: Safeguarding Thresholds in Hostels

10.15. Given the large number of residents at each hostel, many of whom present with significant and complex risk and varying states of vulnerability and anti-social behaviour, there is a need to develop an overarching strategy to monitor and as necessary respond to escalation of behaviour of concern related to relationships between hostel users.

- **Action:** For Health, Housing and the Local Authority to develop an Escalation Procedure in order to be able to respond to concerning behaviour from one hostel resident to another by use of planning and communication across teams and agencies. The procedure will also take into account the need for the 'global' situation within a hostel to be ascertained on a regular basis in order to assess the collective risk presented by having large numbers of people with chaotic lifestyles living together in one place. This process will be completed within six months of the publication of this report.

Recommendation Eight: Accommodation Pathways Working

10.16. Of the various hostels based in Tower Hamlets, the client group has changed over the years and now includes a greater number of service users under the care of secondary mental health services. Placements are accessed via the homeless services HOST Team but at the time of the incident there was no consistent system for placement review to explore potential move-on nor a forum to discuss interface issues and referrals pathways.

- **Action:** An Accommodation Pathways Working Group has now been established and meets every two months with membership including senior Trust managers and clinicians, LBTH Supporting People commissioners and a senior representative of the HOST Team. This process will be reviewed within six months of the publication of this report.

Recommendation Nine: Dual Diagnosis Service

10.17. Good practice has been highlighted regarding the relationship between the CMHT and Dual Diagnosis Service, the Specialist Addiction Unit, the hostel and Health E1 Medical Centre. However, issues have been raised regarding the operation of the Dual Diagnosis Service in terms of its relationship with partner addiction services and referral pathways.

- **Action:** The Trust, the London Borough of Tower Hamlets and housing will review the Dual Diagnoses Service strengthening the input for this large

cohort of clients who currently do not meet the CMHT threshold. This work should be completed within six months of the publication of this report.

Recommendation Ten: Ethnicity, Diversity and Cultural Competence

10.18. Mr X was from an East African cultural background and as such there was an opportunity to explore issues surrounding stigma, denial of symptoms and masking of symptoms which can be common features in people of this background, however this was not explored.

- **Action:** To develop workshops involving themes of the stigma of mental illness and associated features of masking and denial of symptoms, in the context of comparison of various cultural norms as well as an appreciation of the service user as an individual who may or may not share various cultural/ social values. This work should be embedded within six months of the publication of this report.

Recommendation Eleven: Internal Investigation Findings Sharing

10.19. The Trust internal investigation and joint Commissioner investigation process did not communicate its findings to all of the stakeholders concerned. This prevented learning from taking place and the timely development of safer practice. This work should be embedded within six months of the publication of this report.

- **Action:** In future all multi-agency reports will be shared across all of the relevant agencies via a formal briefing process.